IN THE HIGH COURT OF SOUTH AFRICA

(WESTERN CAPE DIVISION, CAPE TOWN)

CASE NO: 8462/2012

In the matter between:

PETER ALLESANDRO FORELLI DANIELS Plaintiff

And

MINISTER OF DEFENCE Defendant

JUDGMENT: 21 JUNE 2016

ALLIE, J:

1. Plaintiff, a corporal in the South African Airforce, instituted an action for damages arising out of the alleged negligent medical treatment he received at 2 Military Hospital, Wynberg, Cape Town.

2. The determination of the merits of the claim is being adjudicated separately from the determination of the quantum of plaintiff's claim.

3. This court is seized only with the determination of the merits at this stage.

The grounds of negligence alleged by plaintiff

4. The medical practitioners that treated the plaintiff at 2 Military Hospital, allegedly failed to:

   4.1. diagnose a perforation of the bowel and the resultant sepsis;

4.2. perform or cause to be performed any and/or adequate special investigations to determine the cause of Plaintiff's symptoms;

4.3. keep Plaintiff under close , careful and regular observation so that his symptoms could be treated timeously and appropriately;

4.4. pay any and/or adequate regard to Plaintiff's persistent symptoms;

4.5. provide appropriate treatment for the perforation of the bowel timeously, adequately or at all;

4.6. act with due care;

4.7. diagnose and treat a bowel obstruction;

4.8. carry out further and/or special investigations, including, *inter alia,* a laparotomy or laparoscopy to establish the cause(s) of the bowel obstruction and to treat Plaintiff accordingly;

4.9. diagnose that the bowel obstruction was caused by a volvulus and treat Plaintiff accordingly; and

4.10. provide appropriate treatment timeously or at all so as to avoid further complications such as perforation of the bowel.

5. Plaintiff alleges in his particulars of claim that as a result of the negligent conduct of Defendant's employees, Plaintiff suffered the following *sequelae*:

5.1. a perforation of the bowel and sepsis of his abdomen resulting in a prolonged period of recuperation;

5.2. he incurred hospital and medical expenses, which he would otherwise not have incurred;

5.3. he will in the future incur hospital and medical expenses;

5.4. he sustained shock, pain, suffering, discomfort and a loss of amenities of life;

5.5. he has in the past and will in the future suffer loss of earnings.

Defendant's denial of negligence

6. Defendant, in its plea, denied Plaintiff's allegations of negligence and alleged the following:

6.1. Defendant denied that there was any failure to diagnose the perforation of the bowel and resultant sepsis of the bowel as there was no clinical or any other diagnostic indication that the Plaintiff had suffered a perforation of his bowel or sepsis whilst the Plaintiff was under Defendant's care;

6.2. Defendant denied any failure to perform special investigations because Defendant's employees performed a whole array of special investigations to determine the cause of Plaintiff's ongoing symptoms;

6.3. Defendant alleged that on or about July and August 2011, surgeons in the employ of Defendant offered to perform a diagnostic laparoscopy but Plaintiff refused to give his consent to the laparoscopy after being requested to do so;

6.4. Plaintiff accordingly failed to mitigate his losses by declining the diagnostic laparoscopy;

6.5. Defendant avers that Plaintiff was kept under close careful and ongoing regular observation and provided timeous, appropriate and ongoing treatment for the Plaintiff and attention to his symptoms;

6.6. Defendant denies that there was any clinical, diagnostic or any other medical indication that the Plaintiff had perforated his bowel whilst under Plaintiff's care;

6.7. Defendant denies that it breached any agreement between itself and Plaintiff and any legal duty that it had towards Plaintiff.

7. In response to specific questions contained in Plaintiff's request for Trial Particulars concerning when the laparoscopy was offered to Plaintiff, which surgeons offered it and why Plaintiff refused to give consent to it, Defendant stated that it was offered between 8 to 12 July 2011 by Dr Marais in consultation with all doctors attending the surgical ward round and that Plaintiff should be asked why he refused to consent.

Chronology of Plaintiff's illness and treatment

8. The facts are briefly as follows.

9. Plaintiff became ill on board a vessel on 22 May 2011. He was treated on the vessel when he complained of a swollen and painful stomach, nausea and vomiting. The doctor on board the ship considered intussusception, i.e. When a part of the intestine prolapses into the other part. It was arranged for him to be airlifted to 1 Military Hospital in Pretoria.

10. That is where he had a sonar and a gastroscopy. 1 Military Hospital noted that he had abdominal pain and vomiting for 2 days.

11. The reason given for the request for the abdominal ultrasound and pelvic sonar are as follows:

    ’? *? abdominal obstruction??”*This is a query of bowel obstruction.

12. ”The pelvic sonar report showed: “ *Clear ascites visualized in the right and left iliac fossa++ Dilated loops large .”bowel loops seen pelvic.? ileus ? obstruction.*”

13. The abdominal ultrasound revealed the following: “*There is a small amount of clear fluid in the lower abdomen. The bowels appear dilated + stillstanding in keeping with ? ileus ? subacute obstruction. No obvious appendix mass or abcess visualized. This does not exclude acute appendicitis. An X-ray is indicated.*”

14. The request for an X-ray on 25 May 2011 shows the following: “*26 year old presenting with abdominal pain. Distended bowel loops on ultrasound. ? bowel obstruction.*”

15. The radiologist/sonographer report dated 27 May 2011 reveals the following;

    “*severe gastritis and multiple small ulcers.”*

16. He was discharged from 1 Military Hospital on 27 May 2011 and he took a flight to Cape Town while still in plain and vomiting.

17. When he first went to 2 Military Hospital upon his return to Cape Town, Plaintiff was given a drip, X-rays were taken and they sent him home without admitting him.

18. He returned to hospital on 2 June 2011 and he was admitted until 7 June 2011.

19. He had a CT Scan of the abdomen and pelvis which showed the following: "*Distended fluid and gas-filled loops of the small bowel are seen. Appearance of slight thickening of the wall of the small bowel is seen but it can be due to under distension of the small bowel loops.? Infective ileitis?"* Clearly the radiologist was querying a possible infective ileitis at that stage, but was also concerned about the distended bowel loops.

20. On 6 June 2011, a request was made for a private practitioner's services to be used to conduct a small bowel study and follow through because the machine at 2 Military Hospital wasn't working but the Plaintiff did not have the small bowel follow through study with a private practitioner but had to wait until the Defendant's machine was operational.

21. At 01h50 am on 8 June, Plaintiff was back at 2 Military Hospital complaining of severe abdominal pain and vomiting. He was seen by Dr Y. Parker in casualty who discussed his condition with Dr Boggenpoel of the surgery department. Dr Parker noted the following after the discussion: "*Patient not for admission; element of malingering; all tests done for patient already; Give i/v i Panteloc and i/v i Stemetil.*"

22. Plaintiff remained on sick leave but he was re-admitted to 2 Military Hospital on 24 June 2011 until 18 July 2011 after his admission was initially refused on 23 June 2011. He returned on 24 June 2011 after being referred to hospital by his Commanding Officer.

23. The clinical notes of 23 June 2011 show he was seen on 2 June 2011 with abdominal cramps and discharged on 7 June 2011 after a CT scan of the abdomen and a gastroscope. He was discharged with a diagnosis of gastritis and on 23 June 2011, he again presented with the same problems. His abdomen was noted to be slightly tender. He was discharged on Buscopan, Tramadol and Lacson and noted to still have Losec and Aciban. He was to return on 30 June 2011 for another gastroscope.

24. On 8 July 2011 a small bowel study and follow through was eventually carried out. It showed, inter alia, the following: " *Delayed transit time with dilated featureless loop with a maximum diameter of 5,5cm…Dilated featureless distal ileal loop. An internal transomental small bowel hernia is a diagnostic consideration*."

25. On 11 July 2011 a further gastroscopy was performed on Plaintiff.

26. Plaintiff went home on a pass from the hospital from 12 to 14 July 2011 and again from 14 to 18 July 2011.

27. On 18 July 2011 Plaintiff was sent to the dietician after the morning ward round by the doctors and discharged.

28. On 21 July 2011, Plaintiff saw Dr Marais as an outpatient for a follow-up consultation. Dr Marais recorded the following: *"Abdominal pain, nausea, vomiting investigated extensively, no cause found. Now improved. Tolerated food well. Still in pain over bladder when he urinates. Sometimes epigastric pain. Was seen by a dietician. Still needs to gain weight. Citrus soda prescribed."*

29. On 24 July 2011, Plaintiff had a consultation at the Psychology Department of 2 Military Hospital.

30. On 3 August 2011, Plaintiff saw Dr Du Toit at the Urology Department of the hospital. This doctor noted a weight loss of 20kg and " *abdominal pain since June. Also suprapubic pain, dysuria, penile pain, left orchialgia all started while in hospital. No nocturia no frequency & severe dysuria, perineal pain while urinating and left flank pain… ? internal hernia ? laparoscopy.* The urologist was also querying a possible internal hernia and whether a laparoscopy should be performed.

31. On 10 August 2011, the Plaintiff was seen at the Urology Department of the hospital again by Dr Theron who recorded the following: " … *Still pain left inguinal area. Audible bowel sounds. ? Femoral hernia left, internal hernia.. Send to Surgery. Strongly consider diagnostic laparoscopy/laparotomy."*

32. On 15 August 2011 Plaintiff was admitted to Tygerberg Hospital for an emergency laparotomy.

33. Tygerberg Hospital's histology report records, *inter alia*, the following:

" *Clinical finding is a sealed off terminal ileum and perforation of unknown reason. Macroscopic specimen consists of a part of terminal ileum. The entire specimen measures 300mm. The medial part of the small bowel shows a twisted area with perforation… A small part of the omentum is present. Microscopic sections of the strangulated bowel is in keeping with ischemic colitis, characterised by mucosal sloughing with haemorrhage into the lamina propria. The subepithelial layers are also undermined and show extensive granulation tissue with organizing inflammation as well as perotinitis. Comment: The histology is in keeping with the macroscopic description of a volvulus. Diagnosis: Colectomy Ischemic colitis.*"

34. Plaintiff was discharged from Tygerberg hospital on 14 September 2011 and the diagnosis was given as bowel obstruction.

Defendant's Medical Expert

35. Dr Marais testified as one of the doctors attending to the Plaintiff, the doctor under whose supervision the other doctors in the Surgical ward attended to the Plaintiff and as an expert witness for the defendant.

36. Dr Marais acknowledged that Plaintiff's mother complained to him about Dr Motale and other medical personnel being abrupt with Plaintiff. He undertook to speak to his staff, which he did.

37. Dr Marais accepted that it was inappropriate for medical personnel to label the Plaintiff as a malingerer and not take his complaints seriously but he denied that the personnel at 2 Military Hospital behaved in that manner.

38. Dr Marais testified that Plaintiff's symptoms included nausea and vomiting which were constant but the pain he experienced appeared to vary in its locality and intensity. A previous gastroscope undertaken at 1 Military Hospital showed duodenal ulceration and plaintiff had gastritis. He said that the Plaintiff also had symptoms that could be attributed to a bladder problem and appendicitis. He accordingly could not make a definitive diagnosis. He didn't see any fluid in the stomach which is what he would expect to see if there was a bowel obstruction. The ulcers were caused by the Helicobacter Pylori bacteria, which was treated with antibiotics and by the time the Plaintiff had a third gastroscope, the ulcers had healed. The Plaintiff was referred to a Urologist because his suprapubic pain was indicative of a need for urological investigation. He explained that bowel pain is a diffused pain and is not easy to pin point because it is located over a large area. He explained that an ileus is an effect of another cause such as diverticulitis, perforation or infected appendix which could all lead to an ileus. He says the Plaintiff's symptoms and the results of the gastroscope, X-ray and ultra sound did not support a provisional diagnosis of a small bowel obstruction.

39. Dr Marais disagreed with Plaintiff's expert, Dr Lebos that Plaintiff had a transomental hernia of the small bowel.

40. He said that a volvulus which is a twisting of the bowel was not shown on the barium meal and follow through nor on the CT scan. He believed that the pathologist had no grounds for concluding that a volvulus existed as seen on the Tygerberg Hospital histology report because the volvulus would have to be a clinical finding. That report also states that the cause of the perforation is unknown and therefore he doesn't believe that the perforation was caused by a transomental hernia.

41. Although the results of the bowel follow through study came back with abnormalities, it didn't show the existence of an obstruction. He said that he initially thought he should investigate the small bowel but the Plaintiff had an infection and he thought that it would settle on antibiotics but it didn't and so he wanted to conduct a further investigation, namely a laparoscopy/laparotomy.

42. Dr Marais said that on 7 July 2011, after he had the result of the x-rays and he knew the results of the follow through, he discussed with the Plaintiff that the next procedure to conduct would be the laparoscopy/laparotomy and he explained what the procedure entailed. He merely asked Plaintiff at that stage to think about having that procedure and he would discuss it with the Plaintiff again later. He said that when the Plaintiff returned to hospital on 14 July 2011 after being away on pass from 12 July, he would have discussed the

laparoscopy/laparotomy with the Plaintiff during the ward round. He however made no notes that he discussed it with plaintiff.

43. According to Dr Marais, the plaintiff was booked to be seen by the anaesthetist on 14 July 2011 and thereafter he was given a pass to go home for the weekend and return on Monday 18 July 2011 for the laparoscopy/laparotomy procedure.

44. He said that informed consent is usually taken from patients in the afternoon before the procedure.

45. He said that in his letter to the Plaintiff's Commanding Officer dated 13 July 2011, he alleged that he explained to the Plaintiff the need to perform a laparoscopy/laparotomy and he went home to discuss it with his parents. Presumably this was during the period 12 to 14 July 2011, when Plaintiff was on pass.

46. Dr Marais however said in his evidence in chief that he would have discussed the laparoscopy/laparotomy with the Plaintiff finally at the ward round on 14 July 2011. The notes pertaining to that ward round contains mention of a dietician and that the Plaintiff would be on pass for the weekend but no mention of the Plaintiff being booked for surgery on 18 July 2011.

47. Dr Marais admitted that he made no notes of a discussion with the Plaintiff concerning the procedure that he offered nor of the Plaintiff's alleged refusal to have the procedure.

48. Dr Marais said that because the procedure was entered in the surgical diary for 18 July 2011 and crossed out, he must have offered the procedure to the Plaintiff.

49. At the follow-up consultation that Dr Marais had with the Plaintiff after he was discharged, Dr Marais made no note of having discussed with the Plaintiff the consequence of his refusal to have the laparoscopy/laparotomy nor did he mention that procedure at all.

50. Dr Marais said the following during cross examination.

51. Dr Marais agreed that abdominal pain, nausea and vomiting could also be symptoms of a partial or complete bowel obstruction.

52. He said that the results of the abdominal x-ray of 2 June 2011, show features that could indicate radiologically, a possible bowel obstruction but the laparoscopy/laparotomy is an invasive procedure and would not be undertaken before prior investigations.

53. Dr Marais said that when the Plaintiff returned to hospital in the early hours of 8 July 2011 and he was rolling around in pain, his bowel was not distended and

he would expect a complete bowel obstruction when the patient complains of severe abdominal pain and in that instance, there ought to have been bowel distension. Dr Marais admits that it was incorrect for the doctors to tell the plaintiff that all the relevant tests had already been conducted and they didn't have a diagnosis and for them to refuse to admit the plaintiff and send him home instead.

54. He conceded that after the small bowel follow through on 7 July 2011, part of the bowel was dilated and there was delayed transit time.

55. Dr Marais said that its wise but not imperative to record in writing a discussion with the patient in which he/she is advised of the risks and consequences of having the procedure and of refusing to have the procedure.

56. Dr Marais said that he discussed with Plaintiff that if he didn't do the laparoscopy/laparotomy, he would not have a diagnosis. He allegedly didn't discuss the likelihood of a perforation with plaintiff because in partial obstruction, one rarely finds a perforation. He was challenged on how he could remember what he discussed with the plaintiff concerning consent to the procedure 4 and1/2 years ago without any notes having been made of that discussion. He could not support his alleged independent recollection with any collateral evidence. He could not recall on which date he had the discussion with the plaintiff but he believed it was on 8 July 2011 after the plaintiff had the follow through study.

57. He agreed that his letter to plaintiff's Officer Commanding dated 13 July 2011, in which he said that a laparoscopy/laparotomy was a last option, contained an unfortunate choice of words and he should have said that the procedure was "the remaining option."

58. Dr Marais maintained that he and all the medical staff believed that the plaintiff was going to have the procedure after he saw the anaesthetist on 14 July 2011, even though the plaintiff had not given written consent or signed an acknowledgement of the intended procedure.

59. Dr Marais said that on 12 July 2011, the plaintiff was given a pass to go home and discuss the intended procedure with his parents and return on 14 July, 2011, the Friday before the Monday that the procedure was allegedly scheduled for. He could not explain when and how the plaintiff's decision concerning whether to continue to have the procedure was meant to be conveyed to him nor when and how the plaintiff's alleged refusal to have the procedure was conveyed to him and the theatre staff.

60. Dr Marais agreed that in those circumstances, it was important to write down that the patient refused the procedure but he could give no explanation for it not being recorded anywhere in the medical records of the plaintiff.

61. On 11 July 2011, Dr Du Toit, notes that he would discuss a laparoscopy with Dr Marais and Dr Marais couldn't explain in his evidence why it was being considered on 11 July 2011, if Dr Marais already offered the procedure as the

next step in the investigation of the patient's condition on 7 or 8 July 2011, as he alleged.

62. Dr Marais was convinced that he saw the plaintiff on 18 July 2011, the day the procedure was scheduled, but he made no note that Plaintiff refused the procedure and the theatre diary and slate contains no note of such refusal either.

63. Dr Marais saw the plaintiff as an outpatient on 21 July 2011, 3 days after he was scheduled to have the procedure according to defendant, yet Dr Marais made no note of the scheduled procedure nor of the plaintiff's refusal to have it.

64. Dr Marais said that its only an assumption that the perforation and subsequent resection of the plaintiff's small bowel could have been avoided, if the laparoscopy had been carried out while the plaintiff was under his care, because he doesn't know the ultimate cause of the perforation.

65. It was put to Dr Marais whether the plaintiff had a transomental hernia, partial or complete bowel obstruction or an ileus, the plaintiff would nonetheless require a laparoscopy/laparotomy to identify it or exclude it. Dr Marais agreed.

66. Dr Marais persisted with his evidence that the plaintiff did not present with signs of bowel obstruction while under his care, despite several medical practitioners querying bowel obstruction as outlined in the chronology of treatment above.

Plaintiff's Medical Expert

67. Dr Lebos, plaintiff's expert, testified as follows.

68. The pelvic sonar of 24 May 2011 showed ascites, i.e. fluid in the abdomen and dilated loops of bowel. At the time, the possibility of an ileus or obstruction was queried.

69. On 25 May 2011, the ultrasound results referred to distended bowel loops and again a query of bowel obstruction was raised.

70. On 6 June 2011 a CT scan was performed and the report refers to distended fluid- and –gas filled loops of small bowel with a query of infective ileitis.

71. The queries related primarily to a need to investigate a possible obstruction and/or inflammation of the small bowel, yet the medical doctors attending to the Plaintiff sought to exclude several other possible causes other than conducting an investigation of the small bowel.

72. A small bowel follow through study was conducted on 7 July 2011 which revealed a delayed transit time with a dilated featureless distal ileal loop, which was distended to a diameter of 5,5cm. Dr Lebos said that the normal diameter is 2 to 2,5cm. A query was raised that there may be a small bowel hernia but this was not followed up.

73. According to Dr Lebos the study showed a pathology associated with the small bowel and an investigation and if needs be, intervention was required.

74. On 3 August 2011, when Plaintiff was seen by a urologist as an outpatient, a laparoscopy was suggested but not actually arranged.

75. On 10 August the urology department again suggested a diagnostic laparoscopy/ laparotomy but again it was not arranged nor scheduled then.

76. Eventually Plaintiff underwent an emergency laparotomy at Tygerberg Hospital on 15 August 2011 where a terminal ileum and perforation of the distal small bowel of unknown cause was found. He had a resection of the small bowel and reconnection of part of the small intestine.

77. Dr Lebos holds the view that the findings of the laparotomy are consistent with the symptoms and complaints of the Plaintiff all along.

78. Dr Lebos concluded that plaintiff was not treated with the necessary care and skill in the following respects:

    78.1. Further investigations in the form of a laparoscopy/laparotomy were not carried out immediately after the Plaintiff was admitted to 2 Military Hospital, for eg, when the reports of the CT scan, abdominal X-ray reports, gastroscopy and the barium meal and small bowel follow through study were known, especially when those reports are

considered together with the queries raised by the doctors at 1 Military Hospital and by the radiologists at 2 Military Hospital;

78.2. By 6 June 2011 the barium meal and follow through was not conducted although permission to do it privately was sought;

78.3. Although the perforation of the bowel would not have occurred until shortly before the Plaintiff was admitted to Tygerberg Hospital, all the indications are that the Plaintiff had a small bowel pathology and had the laparoscopy/laparotomy been carried out earlier, the perforation of the bowel and the resulting sepsis could have been avoided. In that instance, there would have been no need to do a resection of part of his small bowel and the recurrence of future bowel obstruction would have been less likely because there is a 30 per cent recurrence due to adhesions of the bowel after a resection.

79. Dr Lebos agrees with the initial investigative measures followed at 1 Military hospital, some of which were duplicated at 2 Military hospital, namely, an ultrasound, followed by an abdominal X-ray, a CT scan, followed by a barium meal and follow through study and a gastroscopy. He however believes that after all those tests together with the doctors' clinical observations and the patient's complaints, remained, those factors ought to have caused the treating doctors to do a laparoscopy/laparotomy soon after the follow through study's results were known and it was clear that further investigations were required.

80. Dr Lebos doubts that the Plaintiff had Helicobacter Pylori bacteria and had to be treated for it and for the consequential ulceration because the symptoms that Plaintiff had could not be explained solely by ulceration.

81. Dr Lebos believes that treating the Plaintiff for gastritis was merely treating symptoms without establishing the cause of the gastritis-like symptoms. Dr Lebos agreed that the Plaintiff's complaint of abdominal pain is non-specific but he believes that after all the tests were complete and the doctors still didn't discover a cause, while the results of the investigations show a possibility, although not conclusive, that a bowel obstruction could be occurring, it was necessary for the doctors to exclude the bowel obstruction as a possible cause, hence the need for a laparoscopy/laparotomy.

82. He is of the view that the Plaintiff 's ability to tolerate the barium, indicates that there was a partial obstruction at that stage and the bowel was herniated then.

83. The fact that the Plaintiff lost 20kg according to the medical notes, led Dr Lebos to believe that the Plaintiff had a gastro-intestinal problem.

84. According to Dr Lebos the most likely explanation for the Plaintiff's recurring pain, nausea and vomiting is the following: there was an internal hernia that caused the bowel to twist on its own axis and then un-twist and that process continued until a section of the bowel twisted to such an extent that it caused the blood supply to that section to be cut off which led to a perforation.

85. Dr Lebos took issue with the way Dr Marais wrote to Plaintiff's Officer commanding about offering the laparoscopy/laparotomy to the Plaintiff because Dr Marais said that he explained to Plaintiff that a last option would be to do a laparoscopy/ laparotomy. According to Dr Lebos, that description ties in with Dr Marais' attitude that there was no haste in doing a laparoscopy/ laparotomy.

86. Dr Lebos agrees with Dr Marais that a volvulus in the small bowel is very rare.

87. He disagreed with the proposition put to him on behalf of Dr Marais that a twisted area of the small bowel could occur without a volvulus and as a result of an adhesion by two parts of the bowel. He explained that the mechanism of adhesion was different to the mechanism of twisting on its own axis.

88. It was put to Dr Lebos that Dr Marais would say that he considered Crohn's disease, Yersinia Enterocolitis, infective ilieutis or a lymphoma of the small bowel throughout the period of treatment. Dr Lebos rejected that proposition because Plaintiff's medical records do not contain notes supporting those as possible diagnostic considerations nor were there any tests performed which support those considerations.

89. Concerning Dr Marais' testimony that he did inform the Plaintiff about the benefits of having a laparoscopy/laparotomy, and Plaintiff nonetheless refused to have it, Dr Lebos referred to the Health Practitioners Council of South Africa (HPCSA)'s guidelines for a health practitioner taking informed consent from a patient.

90. Dr Lebos is of the view that a patient must be fully informed of the risks and benefits of having the procedure. In the event of a patient refusing consent, the patient ought to be counselled about the consequences of his/her decision. Dr Lebos is of the view that it is sound practice to have a patient sign a document recording his refusal to consent to the procedure, despite having been informed of the risks associated with such refusal.

Plaintiff's evidence

91. He is now a 31 year old, aircraft mechanic.

92. Before he became ill, he was athletic but he is no longer as active as then.

93. The day after he arrived back in Cape Town after being discharged from 1 Military Hospital, he had extreme pain and vomiting and his parents took him to the casualty section at 2 Military Hospital on 29 May 2011. He was put on a drip, sent for x-rays and sent home in the early hours of the morning.

94. The following day, he again had severe pain and vomiting and his parents took him back to the casualty section, where he was given a drip and medication and again sent home.

95. On 2 June 2011 he went back to hospital with severe symptoms and he was admitted until 7 June 2011, when he was discharged.

96. On 8 June 2011, he was taken back to hospital with the same symptoms but he wasn't admitted. He was sent home with medication and told that he was malingering.

97. On 24 June 2011, after returning to work, he felt tremendous pain and nausea and he was taken back to hospital where he was admitted.

98. He saw a dietician in hospital who also accused him of malingering. He was very upset because his symptoms were real and not imagined.

99. By 10 August 2011, when he saw the urologist as an outpatient, his cramps would come and go.

100. He lost 20 kg in weight and his arms were swollen from the many drips he had.

101. He denied that any doctor at 2 Military Hospital offered to perform a laparoscopy/laparotomy on him and that he refused that procedure.

102. He felt despondent about the lack of effective treatment, lack of a firm diagnosis and the attitude of Dr Motale and the dietician who accused him of malingering.

103. He initially thought that he went on pass from the hospital only on 14 to 18 July 2011, but he was referred to additional medical records that were discovered late and which show that he also went on pass on 12 to 14 July 2011. He conceded that he went on pass both times.

104. He denied that he was booked to have the laparoscopy/laparotomy on 18 July 2011 and that he refused to have the procedure.

Applicable Legal Principles

105. The plaintiff bears the onus of proving that the doctors in the employ of defendant that treated him, did not meet the requisite standard of care and how their alleged failure to do so caused the Plaintiff's medical condition.

106. Defendant bears the onus of establishing that Plaintiff failed to mitigate his damages by his refusal to give his consent for a laparoscopy/laparotomy.

107. It is trite that a plaintiff in a delictual claim is obliged to prove negligence, causation and harm.

108. The test for causation encapsulates a two stage inquiry, namely, a factual test and an inquiry into the close connection between the act or omission and the harm [1]:

"As has previously been pointed out by this Court, in the law of delict causation involves two distinct enquiries. The first is a factual one and relates to the question as to whether the defendant's wrongful act was a cause of the plaintiff's loss. This has been referred to as 'factual causation'. The enquiry as to factual causation is generally conducted by applying the so-called 'but-for' test, which is designed to determine whether a postulated cause can be

[1] International Shipping Co (Pty) Ltd v Bentley **1990 (1) SA 680** (A) at 700 E - I; Siman & Co (Pty) Ltd v Barclays National Bank Ltd **1984 (2) SA 888** (A) at 915B-H; and Minister of Police v Skosana **1977 (1) SA 31** (A) at 35C-E.

identified as a causa sine qua non of the loss in question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such a hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; aliter, if it would not so have ensued. If the wrongful act is shown in this way not to be a causa sine qua non of the loss suffered, then no legal liability can arise. On the other hand, demonstration that the wrongful act was a causa sine qua non of the loss does not necessarily result in legal liability. The second enquiry then arises, viz whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote. This is basically a juridical problem in the solution of which considerations of policy may play a part. This is sometimes called 'legal causation'."

109. Causation has to be proved on a balance of probabilities.[2]

110. In **Minister of Safety and Security v Van Duivenboden [3] [2002] ZASCA 79**, the court held that:

"*A plaintiff is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have*

[2] Lee v Minister of Correctional Services 2013 (2) SA 144 (CC) at para 39
[3] 2002 (6) SA 431 (SCA) at para 25

occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics."

111. It has been held that the "but for" test requires flexibility and a common sense approach when the issue of causation has to be decided on the ground of an alleged negligent omission as opposed to negligent commission. It has been stated as follows:[4]

"*[48] While it may be more difficult to prove a causal link in the context of a negligent omission than of a commission, Lee explains that the "but-for" test is not always the be-all and end-all of the causation enquiry when dealing with negligent omissions. The starting point, in terms of the "but-for" test, is to introduce into the facts a hypothetical non-negligent conduct of the defendant and then ask the question whether the harm would have nonetheless ensued. If, but for the negligent omission, the harm would not have ensued, the requisite causal link would have been established. The rule is not inflexible. Ultimately, it is a matter of common sense whether the facts establish a sufficiently close link between the harm and the unreasonable omission."*

112. In **Loureiro's** case [5], the court made the distinction between the test for wrongfulness and negligence clear, in the following manner:

"*Did Mr Mahlangu act wrongfully and negligently? The enquiries into wrongfulness and negligence should not be conflated. To the extent that the*

[4] Oppelt at para 48

[5] Loureiro and Others v Imvula Quality Protection (Pty) Ltd 2014 (3) SA 394 (CC)

majority judgment of the Supreme Court of Appeal did not distinguish between these, it is incorrect. The wrongfulness enquiry focuses on the conduct and goes to whether the policy and legal convictions of the community, constitutionally understood, regard it as acceptable. It is based on the duty not to cause harm – indeed to respect rights – and questions the reasonableness of imposing liability. Mr Mahlangu's subjective state of mind is not the focus of the wrongfulness enquiry. Negligence, on the other hand, focuses on the state of mind of the defendant and tests his or her conduct against that of a reasonable person in the same situation in order to determine fault."

113. The standard of care the courts expect from a doctor is not the highest standard but rather a reasonable standard. In **Mitchell v Dixon** [6] it was held to be as follows:

"*A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not***."**

114. The degree of care and skill expected of a diligent medical practitioner in the position that defendant's employees found themselves, namely, as doctors treating a patient with continuous and unresolved symptoms and complaints, all of which remained constant, save for the exact location of pain in the abdomen, which varied, is that of a reasonably skilled practitioner.[7]

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[6] 1914 AD 519 at 525

[7] Mitchell v Dixon supra; Castell v de Greef 1993 (3) SA 501 (C); Pringle v Administrator Transvaal 1990 (2) SA 379 (W); Joubert; LAWSA Vol 17, Part 2 page 39

115. The test is ultimately how would reasonable medical practitioners in the position of defendant's employees have conducted themselves,[8] what procedures would they follow, what information would they impart to the patient, how would they disclose that information and at what pace and with what amount of rigour would those measures be employed for it to constitute reasonable and diligent conduct.

116. A further consideration is the level of insight that a diligent and reasonable practitioner in the position of the treating doctors ought to possess and ought to demonstrate in taking account of the likely consequences occasioned by a delay in making a definitive diagnosis and in sending a patient home without such a diagnosis before a patient can receive treatment for a definitive diagnosis.

117. A court can't absolve a defendant merely because medical evidence shows a sound medical practice. If professional opinion overlook an obvious risk, it will not be a reasonable practice.[9]

118. A failure to act in accordance with an awareness of possible danger as a reasonably skilled and careful doctor ought to, has been found to constitute negligence.[10]

[8] Buls v Tsatsarolakis 1976 (2) SA 891 (T) at 94 C - E
[9] Michael v Linksfield Park Clinic (Pty) Ltd 2001 (3) SA 1188 (SCA) at para 37
[10] Blythe v Van den Heever 1980 (1) SA 191 (A) at 220 H – 221 G

119. The National Health Act [11] applies to all medical practitioners who are healthcare providers and applies to defendant's employees at 2 Military Hospital.

120. The Act makes specific provision for a patient to be adequately informed of his/her status unless it will be adverse to the patient's health if he/she were so informed, the range of diagnostic procedures and treatment options available, the risks, benefits, costs and consequences associated with such options, the patient's right to refuse health services and the implications, risks, obligations of such refusal.[12]

121. The Act further provides for a patient to be given sufficient information about the recommended procedure and/or treatment to enable a patient to make an informed decision and accordingly give informed consent or be aware of all the requisite information should he/she refuse to give consent.[13]

122. The HPCSA has formulated ethical guideline for: Seeking Patient's Informed Consent: The Ethical Considerations. Those guidelines are applicable to all healthcare practitioners registered with the HPCSA.

123. The guidelines provide that: "*these guidelines form an integral part of standards for professional conduct against which a complaint of professional conduct will be evaluated.*"

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[11] Act 61 of 2003
[12] Section 6
[13] Section 7

124. The guidelines incorporate the provisions of the National Health Act which, together with the guidelines, constitute a yardstick against which standards of professional conduct can be measured.

125. The guidelines provide further as follows:

"*3.3.1 Patients have a right to information about any condition or disease from which they are suffering. This information should be presented in a language that the patient understands. The information which patients want or ought to know, before deciding whether to consent to treatment or an investigation, includes:*

3.1.3.1 Details of the diagnosis and prognosis, and the likely prognosis if the condition is left untreated, must be made clear to the patient;

3.1.3.2 Uncertainties about the diagnosis, including options for further investigation prior to treatment;

3.1.3.3 Options for treatment or management of the condition, including the option not to treat;

3.1.3.4 The purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatments such a methods of pain relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure including common and serious side effects;

3.1.3.5 For each option, explanations of the likely benefits and the probabilities of success, and discussion of any

serious or frequently occurring risks, and of any lifestyle changes which may be caused or necessitated by the treatment;

…

3.1.3.10 a reminder that patients can change their minds about a decision at any time;

3.1.3.11 a reminder that patients have a right to seek a second opinion;

3.1.3.12 … ”

126. On the subject of “PRESENTING INFORMATION TO PATIENTS” the guidelines provide:

3.4.1 “Obtaining informed consent cannot be an isolated event. It involves a continuing dialogue between heath care practitioners and their patients which keeps them abreast of changes and conditions of patients and the treatment or investigation the practitioner proposes. Whenever possible, healthcare practitioners should discuss treatment options at a time when the patient is best able to understand and retain the information.

3.4.2 To be sure that their patients understand, healthcare practitioners should give clear explanations and give the patient time to ask questions. In particular, healthcare practitioners should:

3.4.2.1 Use up to date written material, visual and other aids to explain complex aspects of the investigation, diagnosis or treatment where appropriate or practicable; …

3.4.3.2 Where appropriate, discuss with patients the possibility of being accompanied by a relative or friend, or making a tape recording of the consultation;

3.4.2.4 Explain the probabilities of success, or the risk of failure of, or harm associated with options for treatment, using accurate data; …"

127. As to the "MEANING OF INFORMED CONSENT" the guidelines provide:

"4.1 The South African courts have held that legally for a proper informed consent the patient must have:

4.1.1 Knowledge of the nature or extent of the harm or risk;

4.1.2 Appreciated it and understood the nature of the harm or risk;

4.1.3 Consented to the harm or assumed the risk; and

4.1.4 The consent must have been comprehensive, (i.e. extended the entire transaction, inclusive of its consequences)."

128. The Guidelines stipulate that the patient must furnish an "EXPRESS CONSENT" to the procedure or investigation and they provide:

"13. EXPRESS CONSENT

13.1 Patients can indicate their informed consent either orally or in writing;

13.2 In some cases, the nature of the risks to which the patient might be exposed make it important that a written record is available of the patient's consent and other wishes in relation to the proposed investigation and treatment.

This helps to ensure later understanding between the healthcare practitioner, the patient an anyone else involved in carrying out the procedure or providing care.

…

13.4 Healthcare practitioners must use the patient's case notes or the consent form to detail the key elements of the discussion with the patient, including the nature of the information provided, specific requests by the patient, and details of the scope of the consent given."

129. On Dr Marais' evidence, he and the medical staff acting under his supervision clearly didn't comply with the letter or the spirit of the guidelines fully.

Evaluation of Expert Evidence

130. A court has to evaluate expert evidence in the following manner:

"*What was required of the trial Judge was to determine to what extent the opinions advanced by the experts were founded on logical reasoning and how the competing sets of evidence stood in relation to one another, viewed in the light of the probabilities*." [14]

131. Before I embark on that evaluation, it is necessary to discuss the independence of the defendant's medical expert. I am not entirely convinced that the State Attorney's *modus operandi*, which may well be linked to ostensible cost saving measures, which involves using the medical practitioner whose conduct is the

[14] Louwrens v Oldwage 2006 (2) SA 161 (SCA) at para 27

subject of the litigation, to testify as the attending or supervising doctor and as an expert, is a sound and acceptable practice for an officer of the court to embark upon.

132. An expert witness is meant to assist the court in its findings on issues pertaining to medical expertise.

133. The attending or supervising doctor, does not comply with the requisites of an independent expert witness. He/she is not able to bring to bear his /her independent expert opinion based on his/her knowledge, skill and experience, which must be clouded by his own personal involvement in the treatment of the patient on the facts of the case and to provide the court with a sound medical basis, for his/her conclusions. A witness who is integrally linked with the medical treatment of a patient will find himself in a position where he feels compelled to justify his decisions and conduct.

134. The duties of an expert witness is aptly stated by Justice Cresswell in **National Justice Compania Naviera SA v Prudential Assurance Company Limited** (also known as the **" Ikarian Reefer" case**) [15] as follows:

"THE DUTIES AND RESPONSIBILITIES OF EXPERT WITNESSES

The duties and responsibilities of expert witnesses in civil cases include the following:

[15] [1993] 2 Lloyds Rep 68.

1. *Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation.*
2. *An expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his experience.*
3. *An expert witness should state the facts or assumption upon which his opinion is based, He should not omit to consider material facts which could detract from his concluded opinion.*
4. *An expert witness should make it clear when a particular question or issue fall outside his expertise.*"

Summary of the Alleged Failure to Exercise a Duty of Care

135. On 24 May 2011, while the plaintiff was in 1 Military Hospital, a bowel obstruction was considered as a possible diagnosis when the pelvic sonar results were considered.

136. The report on the abdominal ultrasound/sonar of 24 May 2011, also shows that the radiologist queries a possible sub-acute obstruction.

137. The clinical findings shown on the abdominal x-ray results dated 25 May 2011 state: " *Distended bowel loops on ultrasound*". This is a further reference to a need to investigate the bowel and why it had distended loops. The rationale for requesting the x-ray is given as possible bowel obstruction.

138. When plaintiff was admitted to 2 Military Hospital from 2-7 June 2011, he had a CT scan of the abdomen and pelvis which showed *inter alia*, *"distended and fluid- and-gas- filled loops of small bowel".*

139. The hospital obtained authorisation to have an emergency small bowel follow through study carried out privately as 2 Military Hospital's machine wasn't working. The authorisation was granted on 6 June 2011 but despite the authorisation, plaintiff was discharged on 7 June 2011 without performing the study.

140. Even though plaintiff came back to hospital in the early hours of the morning of 8 June 2011 with complaints of severe abdominal pain and vomiting, he wasn't admitted but treated with a drip and medication and sent home without definitive diagnosis and without the emergency bowel follow through study having been conducted.

141. Dr Marais conceded that on 8 June 2011, the doctor who treated the Plaintiff ought to have admitted him and should not have sent him home under those circumstances.

142. The diagnostic procedure that ought to have been conducted at that stage was a small bowel follow through study and a laparoscopy/laparotomy.

143. The plaintiff remained on sick leave until he returned to work where his pain and nausea were so intolerable that he was taken back to hospital on 24 June

2011 because his Officer Commanding communicated with the hospital on his behalf.

144. In the 25 days that plaintiff remained under the care of 2 Military Hospital from 24 June to 18 July 2011, no definitive diagnosis was made but he was seen by a team of doctors during daily ward rounds, by a dietician and a psychologist at the request of the attending doctors.

145. Eventually, on 7 July 2011, a small bowel follow through study was carried out. It showed that the small bowel was more than double its normal size and there was a delayed transit time, all of which indicated, at least a need to investigate the internal condition of the small bowel with a laparoscopy/laparotomy. That procedure was not carried out at 2 Military Hospital.

146. Plaintiff was discharged on 18 July 2011 without a definitive diagnosis having been made.

147. Plaintiff saw Dr Marais in a follow-up consultation on 21 July 2011, but no mention was made in the notes concerning that visit, of a laparoscopy/laparotomy.

148. On 3 August 2011 and 10 August 2011, the Plaintiff saw doctors in the urology department at 2 Military Hospital who both strongly recommended admission to the surgical ward for a laparoscopy/laparotomy but nothing to that effect was arranged for the plaintiff.

149. On 15 August the plaintiff was admitted to Tygerberg Hospital where he had an emergency laparotomy where a perforation of his distal small bowel was found.

Evaluation

150. In **Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape** [16] the following extract from the majority judgment set out the approach a court should adopt to the evaluation of expert evidence as follows:

"[36] The correct approach to the evaluation of medical evidence is the one laid down by the Supreme Court of Appeal in Linksfield where it held that—

'it is perhaps as well to re-emphasise that the question of reasonableness and negligence is one for the court itself to determine on the basis of the various, and often conflicting, expert opinions presented. As a rule that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court's reaching its own conclusion on the issues raised.

. . .

Although it has often been said in South African cases that the governing test for professional negligence is the standard of conduct of the reasonable practitioner in the particular professional field, that criterion is not always itself a helpful guide to finding the answer.

. . .

[16] 2016 (1) SA 325 (CC) at para 36

That being so, what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning. That is the thrust of the decision of the House of Lords in the medical negligence case of Bolitho v City and Hackney Health Authority ***[1997] UKHL 46; [1998] AC 232*** *(H.L.(E.)). With the relevant dicta in the speech of Lord Browne-Wilkinson we respectfully agree. Summarised, they are to the following effect.*

The court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached 'a defensible conclusion' (at 241G-242B). If a body of professional opinion overlooks an obvious risk which could have been guarded against it will not be reasonable, even if almost universally held (at 242H).

A defendant can properly be held liable, despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable. However, it will very seldom be right to conclude that views genuinely held by a competent expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both

capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide 'the benchmark by reference to which the defendant's conduct falls to be assessed' (at 243A-E).

. . .

This essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of Dingley v The Chief Constable, Strathclyde Police ***2000 SC (HL) 77*** *and the warning given at 89D-E that:*

[O]ne cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or disproved – instead of assessing, as a judge must do, where the balance of probabilities lies on a review of the whole of the evidence.' "

151. The treating doctors in the surgical ward at 2 Military Hospital clearly did not consider the plaintiff's condition to be sufficiently serious nor sufficiently urgent to warrant a laparoscopy/laparotomy in the days immediately following the small bowel follow through study which was conducted on 7 July 2011.

152. On Dr Marais, evidence, he eventually considered that the Plaintiff may have a partial obstruction of the small bowel but he didn't consider it to be so serious

that it would cause a perforation because in his view, partial obstructions don't result in perforations.

153. That particularly imprudent approach taken by Dr Marais, is not supported by the *prima facie* view of a bowel obstruction taken by the medical practitioners at 1 Military Hospital at a much earlier stage nor by the radiologists at 2 Military Hospital, nor by the urology department's doctors at 2 Military Hospital nor by plaintiff's expert, Dr Lebos.

154. The attitude adopted by the doctors in the surgical ward and the casualty doctors in consultation with the surgical ward's doctors towards the treatment and care of the plaintiff is a particularly cavalier one.

155. Dr Marais failed to explain why he deemed it prudent to even allow the plaintiff to go on pass for 5 days in one week, namely, the last week of plaintiff's stay in the hospital without first establishing a definitive diagnosis, nor has he adequately explained why plaintiff was discharged on 7 June 2011 without a definitive diagnosis and again on 18 July 2011 without a definitive diagnosis, all the while, without recording the Plaintiff's alleged refusal to have the laparoscopy/laparotomy, particularly since he knew that plaintiff had returned to hospital more than once with the same complaints, and he knew that those complaints started in May 2011 and were still being made in July 2011.

156. Dr Marais' failure to record the discussion he allegedly had with plaintiff about giving informed consent for the procedure is inexplicable in view of his

knowledge that the Plaintiff's Commanding Officer considered plaintiff's complaints seriously enough to warrant his intervention on plaintiff's behalf.

157. The decisions taken by the doctors treating Plaintiff as outlined above, are not supported with reference to sound medical procedure and protocol nor does it accord with the common sense and logic required to avert a small bowel perforation.

158. Their attitude is indicative of either a cavalier approach or an overemphasis on cost saving at the expense of the wellbeing of the patient. The failure to have the bowel follow through study performed by a private hospital appears to be a cost saving measure.

159. The negligence of the doctors treating the plaintiff at 2 Military Hospital was evidently a continuous series of omissions and failure which culminated in the necessary procedure not being performed timeously and at all.

160. The attending doctors' treatment of the plaintiff is fraught with behaviour which demonstrates their remiss-ness, which is amply demonstrated by the following questions, for example:

    160.1 How could the doctors discharge him the day after they obtained authorisation to have a small bowel follow through study done privately?

    160.2 How could they discharge him without a definitive diagnosis?

    160.3 How could they send him home without admitting him on 8 July 2011?

160.4 How could they only do the small bowel follow through study on 7 July 2011 which is more than 30 days after he was considered to be a candidate for it to be carried out on an emergency basis?

160.5 How could they not consider it imperative to do a laparoscopy/laparotomy by 8 July 2011 but instead send him on pass on 12 July?

160.6 When he returned on 14 July 2011, how could they not establish before he was sent to the anaesthetist whether he will consent to the laparoscopy/laparotomy?

160.7 How could they not record his refusal of consent and their discussion with him about the procedure?

161 One explanation for the treating doctors' conduct as outlined above is the laissez faire approach that those doctors had towards plaintiff's complaints and symptoms.

162 Dr Marais accepts that the next procedure that he had to perform on plaintiff to establish a definitive diagnosis, was a laparoscopy/laparotomy which would determine how the internal mechanisms of the small bowel of plaintiff was functioning.

163 Dr Marais had ample time and opportunity to conduct that investigation because the plaintiff remained under his care from 7 July 2011 when he had the bowel follow through study until 18 July 2011.

164 Dr Marais, on his own evidence, saw no cause for acting speedily in having the procedure scheduled.

165 In that respect, Dr Marais' failure to arrange a laparoscopy/laparotomy is an omission, which, led to the plaintiff being discharged while his signs and symptoms remain unresolved.

166 Dr Marais placed great store on the allegation that the plaintiff's abdominal pain wasn't constant as it moved around to different loci in the abdomen and it varied in its intensity. No mention is made of the obvious symptomatic relief that the medication prescribed to plaintiff would have given plaintiff and the extent to which the medication may have masked his pain. After all, if a patient is treated with anti-spasmodic and pain relieving medication, one would expect the pain to vary.

167 The treating doctors' failure to act expeditiously in arriving at a definitive diagnosis appear to have been influenced by their perception that plaintiff's symptoms were to some extent improving, albeit, only mildly and temporarily.

168 It follows logically, that if the root causes of the pathology are not addressed, the disease/illness will become more pronounced as time passed.

169 Dr Marais refused to accept that the untreated small bowel pathology caused the perforation because he alleged that he does not know what caused the perforation.

170 Dr Lebos interpreted the histology report of Tygerberg Hospital which contained, *inter alia*, clinical findings that the perforation was caused by a volvulus. Dr Marais agreed that even if the plaintiff had a transomental hernia, partial or complete bowel obstruction or an ileus, the plaintiff would nonetheless require a laparoscopy/laparotomy to identify it or exclude it.

171 In view of that concession, the defendant's disavowel of the cause of the perforation is of no moment.

172 Dr Lebos was emphatic that plaintiff exhibited symptoms consistent with a bowel obstruction. While Dr Marais' response thereto is that the symptoms were largely non-specific.

173 The investigations conducted by the treating doctors, together with the symptoms and signs exhibited by plaintiff ought to have motivated those doctors to conduct further investigation as a matter of urgency, since plaintiff had been suffering for two months by the time he was finally discharged from 2 Military Hospital.

174 I, find that the negligent failure of the treating doctors in the employ of defendant extended to a failure to adequately and expeditiously investigate, the cause of plaintiff's small bowel pathology timeously and at all.

175 The moral convictions of society and the National Health Act and ethical considerations require medical practitioners to treat patients promptly and

without fail, to establish the cause of an illness or refer the patient to someone who can attempt to establish that cause and to explain to a patient, the consequences of not making a definitive diagnosis.

176 A conflict of interest may arise when a medical practitioner is in the employ of the patient's employer and has to practice within a framework of cost saving measures, for the benefit of the employer.

177 An example of such measures occurred when the follow through study couldn't be performed promptly because the machine was inoperable and authorisation for the study to be conducted with a private institution was granted but not acted upon.

178 Ultimately a medical practitioner's oath demands of him/her to place the interests of the patient before any cost saving considerations or other conditions of employment. A failure to do so is wrongful conduct.

179 Causation has been established with Dr Lebos' evidence that a laparoscopy/laparotomy conducted at an earlier stage would have revealed that the small bowel was twisting on its own axis and in danger, at least, of perforating. Dr Marais' disagreed with what caused the perforation but he could not deny, that laparoscopy/laparotomy would have revealed the nature of the pathology, in the small bowel.

180 Dr Lebos' evidence that the perforation, if left untreated would cause bile and other impurities to leak into the abdomen, causing sepsis and ultimately death, could not be gainsaid by Dr Marais.

181 Dr Lebos' testimony that a patient who has had a resection of his bowel, is more susceptible to adhesions in the bowel thereafter and is more likely to require surgery again in the future was not challenged with reference to medical authority that disproved it.

182 The plaintiff has, in my view, discharged the onus of proving that the defendant's failure to do a laparotomy/laparoscopy led to the eventual perforation and emergency surgery.

Informed Consent allegedly withheld

183 The issue of informed consent began to loom large in this case when the defendant produced new documents not previously discovered that included a theatre diary and list with the plaintiff's name on which had been deleted. The date of the page in the diary is 18 but no month is stated on the page.

184 No reason is provided on the page in the diary for the plaintiff's name having been deleted from the theatre list.

185 The plaintiff did not need to plead that defendant didn't follow the HPCSA'S Guidelines read together with the National Health Act because the Act and

Guidelines form part of the legal framework for the standard of care and prescribed procedure that all health care practitioners must comply with.

186 Dr Marais gave contradictory evidence about several different stages during plaintiff's period of admission when he allegedly broached the topic of a laparoscopy/laparotomy but he failed to record any, even oblique reference to those discussions.

187 When Dr Marais was pressed for an answer during cross examination about why he didn't explain the adverse consequences to plaintiff of not having a laparoscopy/laparotomy, he said that it wasn't his *modus operandi t*o force a patient to consent. This answer raises more questions than answers. If he felt that he was bound to abide the plaintiff's decision to allegedly refuse consent, all the more reason for him to have recorded that fact, particularly since he had been called upon, only the day before, namely 13 July 2011, to provide a full and detailed written report on Plaintiff's treatment plan and health status to plaintiff's Commanding Officer.

188 The defendant's allegation that a laparoscopy/laparotomy was scheduled for 18 July 2011 but refused by the plaintiff on 14 July 2011 after he saw the anaesthetist does not accord with the probabilities nor is it supported by any collateral evidence other than Dr Marais' expressed intention to perform a laparoscopy/laparotomy which he mentions in his letter of 13 July 2011 and which was sent to the plaintiffs' Commanding Officer.

189 I find that the defendant's medical staff failed to inform the plaintiff of the importance of having a laparoscopy/laparotomy and of the adverse consequences of refusing to have the procedure.

190 I find further, that defendant's evidence that the laparoscopy/laparotomy was scheduled for 18 July 2011 but cancelled because plaintiff refused it, is too improbable to be believed, particularly since the plaintiff had by then persevered with treatment by defendant's medical staff, in an attempt to be cured for the best part of two months.

191 In my view, defendant has not shown on a balance of probabilities, that plaintiff failed to mitigate the harm he suffered.

IT IS ORDERED THAT:

1. The Defendant is liable for such damages as Plaintiff may prove to have arisen out of the Defendant's employees' negligent treatment of Plaintiff at 2 Military Hospital over the period 2 June to 10 August 2011; and

2. The Defendant failed to discharge the onus of proof that the Plaintiff failed to mitigate his damages by refusing to furnish his consent to the carrying out of a laparoscopy and/or laparotomy.

3. A costs order in the following terms is made:

3.1 Defendant is liable for the following costs on an attorney and client scale;

3.1.1 Plaintiff's costs in opposing Defendant's application to adduce further documentary evidence;

3.1.2 The cost of the trial set down for 2 and 3 December 2015;

3.1.3 The reasonable and necessary preparation and consultation costs for the trial and costs of counsel for 2 and 3 December 2015;

3.1.4 The costs of the trial on 18 and 19 April 2016;

3.2 Save for the Orders set out above, Defendant is liable for Plaintiff's costs of suit, on a party and party scale, including the costs of counsel and the reasonable and necessary traveling, accommodation and qualifying expenses of Dr Lebos, general surgeon.

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R. ALLIE